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2016 European guideline on the management of non-gonococcal urethritis published

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On 4 May 2016, the evidence-based '2016 European Guideline on the management of non-gonococcal urethritis' was published online [1]. This guideline is a comprehensive updated version of the European guideline from 2009 [2] and provides up-to-date and detailed guidance regarding aetiology, clinical features, diagnosis, testing, treatment and general management of symptomatic non-gonococcal urethritis in Europe.

The most common organisms implicated are *Chlamydia trachomatis* and *Mycoplasma genitalium*, with the latter perhaps causing more symptoms [3]. Testing male patients with urethritis for *M. genitalium*, preferably with screening for macrolide resistance, is highly likely to improve clinical outcomes [4]. Testing symptomatic patients for *M. genitalium* is therefore recommended.

Of major concern is the increasing azithromycin resistance of *M. genitalium* [5]. Azithromycin, especially single dosage of 1 g, is associated with the development of macrolide resistance in *M. genitalium*, and is likely to increase the circulation of macrolide-resistant strains in the population [5]. Consequently, single dose azithromycin is no longer recommended as first-line treatment for non-gonococcal urethritis.

Updates to the guideline include recommendations on the diagnosis, testing and treatment of non-gonococcal urethritis:

Urethritis should be confirmed by urethral smear microscopy in symptomatic patients.

- Symptoms and negative urethral smear: No empirical treatment. Re-attend for early morning smear if nucleic acid amplification testing (NAAT) was negative and symptoms do not settle.
- All men assessed for sexually transmitted infections, regardless of symptoms, should be tested for

C. trachomatis from a first-void urine specimen and for *Neisseria gonorrhoeae* if they have urethritis. If a NAAT is positive for gonorrhoea, a culture should be performed before treatment.

- All men who have sex with men should be tested for both *C. trachomatis* and *N. gonorrhoeae* from any potentially exposed site.
- Recommended syndromic regimen: doxycycline 100 mg twice daily for seven days. Azithromycin 1 g immediately should not be used routinely because of the increased risk of inducing macrolide antimicrobial resistance with *M. genitalium*.
- If *M. genitalium*-positive: azithromycin 500 mg immediately, followed by a 250 mg oral dose for four days. A test of cure three to five weeks after treatment in those who tested positive for *M. genitalium* should be performed.

In case of persistent and/or recurrent non-gonococcal urethritis, testing for *M. genitalium* using a NAAT, preferably with screening for macrolide resistance, should be considered, as well as testing for *Trichomonas vaginalis* using a NAAT if it is prevalent in the local population. Recurrent non-gonococcal urethritis should only be treated if the patient has definite symptoms of urethritis, or if there are physical signs and microscopic evidence of urethritis on examination.

The guidelines are available [here](#)

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